Volunteer Injury
Report Check List and
Insurance Paperwork

The Winchester Fire and Rescue Department volunteers are covered by Hartford Insurance, through Chesterfield Insurers, Inc.

___ **DO NOT CALL** Nurse Triage (This is for City Employees Only)

___ **DO NOT CALL** the insurance company. If the injury happens during normal business hours please complete the attached insurance information and bring it to the Fire and Rescue Administration Office. If the injury happens after normal business hours or on a weekend make sure that information is passed on to the duty officer and that the paperwork is turned into the Fire and Rescue Administration Office.
Please make sure that the paperwork is completed and legible.

___ Page one (1) and page three (3) of the insurance material requires an officer's signature.

___ Page four (4) of the insurance information must be completed by the attending physician.

___ Volunteer must sign the panel of physicians and go to one of the designated physicians or go to the ER if it is after hours.

___ Make sure that the volunteer knows that all paperwork from the ER/physician must be turned into Fire and Rescue Administration for processing.

HARTFORD FIRE INSURANCE COMPANY
HARTFORD LIFE INSURANCE COMPANY
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

THE HARTFORD

NOTICE OF CLAIM - FOR VOLUNTEER FIREFIGHTER ACCIDENT MEDICAL AND DISABILITY BENEFITS

A claim is being filed for: (Choose one or both of the following)

☑ Medical Benefits ☑ Disability Benefits

Forward Questions/Claims to: Chesterfield Insurers, Inc.
P. O. Box 34220, Richmond, VA 23234
Phone (804) 271-9426 Fax (804) 271-9108

Claim Instructions:
The Policyholder should: Complete Sections I and III
The Claimant should: Complete Sections II-A, II B (if filing a disability claim), III, IV-A and V
The Attending Physician should: Complete Section IV-B

Section I - Policyholder Information - To be completed by Fire Commanding Officer

Policyholder Name: City of Winchester Fire & Rescue		Policy Number: 14-VP-905170
Policyholder Address: 231 E. Piccadilly St, Suite 330 Winchester, VA 22601		Commanding Officers Phone Number: (540) 662-3298
Claimant (Injured Party) Name	Claimant Date of Birth	Claimant Social Security Number
Claimant Gender ☐ Male ☐ Female	Claimant Insured Person Status ☑ Volunteer ☐ Paid FireFighter ☐ Other	
Claimant Address (Street, City, State and Zip Code)		Claimant Phone Number ( )
Date of Accident mm/dd/yyyy	Time of Accident hh:mm ☐ AM ☐ PM	Place of Accident
Complete description of Accident		
Indicate injured body part(s)		
Have you had this condition previously? ☐ Yes ☐ No	Date Sickness first commenced	
Nature of Sickness (if applicable)		

Note - Please also include a copy of the Incident Report (if available)

Policyholder Certification Signature Required:

I hereby certify the Claimant is a member of the group insured under the above Policy and the Injury/Sickness was sustained under adequate supervision while participating in an official Covered Activity.

Title of Commanding Officer	Signature of Commanding Officer	Date

THE HARTFORD

Section II-A Claimant Information - To be completed by Claimant if filing a medical claim

If filing a claim for Medical Benefits:

- Submit itemized medical bills to: Chesterfield Insurers, Inc. P. O. Box 34220, Richmond, VA 23234
  Phone (804) 271-9426 Fax (804) 271-9108
- Sign the Claimant Certification statement listed below

Claimant Certification Signature Required:

I certify the Injury and/or Sickness information provided by the Policyholder in Section I to be true and accurate to the best of my knowledge.

Signature of Claimant _____ Date _____

Section II-B Claimant Information - To be completed by Claimant if filing a disability claim

Normal Occupation (regular job)	Normal Occupation Work Hours
Name of Normal Occupation Employer	Contact Phone Number ( )
Address of Normal Occupation Employer	Contact Fax Number ( )
Contact Name for Normal Occupation Employer	Exact duties unable to perform - Normal occupation
Date last worked Normal Occupation Employer	Date returned to work - Normal Occupation Employer ☐ Full Duty ☐ Light Duty

Verification of Earnings - You must submit proof of earnings.
Attach payroll summary showing pay and hours worked for the 12 months prior to disability. **Your claim will be delayed if you do not submit complete proof of hours worked and your earnings prior to disability.**

Attending Physician's Name	Attending Physician's Phone Number ( )
Attending Physician's Address	Attending Physician's Fax Number ( )

Were you treated in the emergency room? ☐ Yes ☐ No If so, name of hospital and date. _____ Date

Do you have disability (loss of wages) or sick pay coverage through? (Check all that apply)

☐ Your Normal Employer ☐ Worker's Compensation ☐ Other

Attach a copy of check or letter advising of payment amount

I understand that if I perform work of any kind during any period the Hartford has approved my disability claim, I must report all details to The Hartford immediately.

Claimant Certification Signature Required:

I certify the above information and the Injury and/or Sickness information provided by the Policyholder in Section I to be true and accurate to the best of my knowledge.

Signature of Claimant _____ Date _____

Section III - Fraud Warning Statement

Please read the statement that applies to your state of residence and sign the bottom of the page.

For residents of all states EXCEPT California, Colorado, Florida, Kentucky, Maine, New Jersey, New York, Oregon, Pennsylvania, Puerto Rico, Tennessee, Virginia and Washington: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

For residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

For residents of Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

For residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil penalties.

For residents of New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

For residents of Oregon: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto that the insurer relied upon is subject to a denial and/or reduction in insurance benefit and may be subject to any civil penalties available.

For residents of Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

_____ _____

Signature of Policyholder Official (Commanding Officer) Date

_____ _____

Signature of Claimant Date

Section IV - Attending Physician's Statement for Medical and Disability Services
(The patient is responsible for the completion of this form without expense to Company)

Section IV-A To be completed by the Claimant

Name of patient	Social Security Number	Date of Birth

Address of patient *(Street, City, State or Province & Zip Code or Postal Code)*

Name of policyholder	Policy Number
City of Winchester Fire & Rescue	14-VP-905170

I hereby authorize release of information on this form by the below named physician for the purpose of claim processing.

Signed *(Patient)* _____ Date _____

Section IV-B To be completed by the Physician

Claimant Name	Social Security Number	Date of Birth

Diagnosis and Concurrent Conditions (ICD-9 code) *(If fracture or dislocation, describe nature and location.)*

Is treatment due to ☐ Sickness ☐ Accident

When did symptoms first appear or accident happen? Date: _____

When did patient first consult you for this condition? Date: _____

Has patient ever had same or similar condition? ☐ Yes ☐ No If "Yes," state when and describe. Date _____

Nature of surgical procedure, if any, (describe fully) performed CPT Code _____

Is patient still under your care for this condition? ☐ Yes ☐ No Date: _____

Did you refer patient to another physician? ☐ Yes ☐ No

If "Yes", Name, address, telephone number. _____

How long was or will patient be continuously unable to work at **Normal Occupation***? **From** _____ **Thru** _____

How long was or will patient be able to perform some but not all duties of his **Normal Occupation***? **From** _____ **Thru** _____

***LIMITATION (If there is a limitation, check** ☐ Standing ☐ Climbing ☐ Bending ☐ Use of Hands ☐ Sitting ☐ Walking ☐ Stooping ☐ Lifting ☐ Psychological ☐ Other *(State which)* _____

To your knowledge does patient have other health insurance or health plan coverages? ☐ Yes ☐ No
If "Yes", identify.

Attending Physician's Name: *(Please print or type.)*		Telephone Number ( )
License Number		Fax Number ( )
Street address (Street, City, State & Zip Code)		
SS# or E.I.N.#	Degree	Specialty

Signature _____ Date Signed _____

Section V AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Completion of this form will allow us to obtain additional information necessary to process your claim.

To: Any health care provider, employer, benefit plan, insurer, financial institution, consumer reporting agency, educational institution, or Federal, State, or Local Government Agency, including the Social Security Administration and Veterans Administration. I authorize you to disclose to The Hartford[1] a complete copy of any and all of the following personal or privileged information, records or documents relative to:

Insured's Name (*Please print*) Date of Birth Last 5 digits of Social Security Number

Any and all medical information or records, including x-ray films, medical histories, physical, mental or diagnostic examinations, and treatment notes, and including information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health, as such information may be related to my claim for benefits; work information and history, including job duties, earnings and personnel records, and client lists, information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; credit information, including credit reports and credit applications; other financial information, including pension benefits, bank records; business transactions billing, invoices, and payment records; academic transcripts; and information concerning Social Security benefits, including, monthly benefit amounts, monthly payment amounts, entitlement dates, and information from my Master Beneficiary Record. The information obtained by use of this Authorization will be used for the purpose of evaluating and administering my claim for benefits under my benefit plan. Such information shall be referred to herein collectively as "My Information." I understand I have the right to revoke this Authorization for future disclosures, except to the extent action has been taken in reliance upon this Authorization. I must revoke this Authorization in writing directly to The Hartford.

I ALSO UNDERSTAND that once My Information has been disclosed to The Hartford, as permitted under this Authorization, it may be re-disclosed by The Hartford as permitted by law or my further authorization. I authorize The Hartford to use or disclose My Information (i) to my employer for functions related to accommodating my disability; (ii) to the administrator or other service providers of my benefit plan for plan-related functions; (iii) to any claim system used for claims processing or insurance broker to carry out functions related to my benefit plan or claim; (iv) to any health care professional who has treated or evaluated me or who may do so; (v) to other persons or entities performing business or legal services related to my claim, vi) to my employer's workers' compensation insurance carrier or administrator; (vii) as may be lawfully required; or (viii) as may be necessary to prevent or detect perpetration of a fraud.

I understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient. I understand that I have the right to revoke this Authorization for future disclosures The Hartford may make unless The Hartford has taken action in reliance upon this Authorization. I must revoke this Authorization in writing directly to The Hartford. I understand that my medical treatment or payment for medical benefits cannot be conditioned on my allowing The Hartford to re-disclose My Information. The authorizations set forth herein expire two years from the date listed below or upon my revocation, if earlier, but will not exceed the term of my coverage under the policy or benefit plan, except as may be necessary to prevent or detect perpetration of a fraud. I understand that I am entitled to receive a copy of this Authorization upon request. A photocopy or facsimile of this Authorization shall be as valid as the original. If there is a conflict between a prior request for restriction on the disclosure of My Information and this Authorization, this Authorization will control.

Signature of Insured or Guardian Date Relationship to Insured (*if signed by Guardian*)

[1] The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries, including issuing companies Hartford Fire Insurance Company, Hartford Life Insurance Company, Hartford Life and Accident Insurance Company, and its administrative services company Hartford-Comprehensive Employee Benefit Service Company, and any of their parents, affiliates, subsidiaries and/or third-party contractors. Also as used herein, The Hartford provides insurance or claim administration services benefit plan(s).

Rev. 2015-5

WINCHESTER, CITY OF
WORKERS COMPENSATION PANEL OF PHYSICIAN

THE CLOSEST EMERGENCY FACILITY MAY BE USED IN AN EMERGENCY SITUATION. ONCE THE EMERGENCY TREATMENT IS COMPLETED A PANEL PHYSICIAN MUST BE CHOSEN FOR FOLLOW-UP CARE.

_____ I agree to select a doctor, if needed, from the below panel.

_____ I have declined to select a physician from the below panel. I understand that I will have to pay for any medical treatment or doctor's bills, and that I will be denied workers' compensation coverage for any absence based on a disability which is not certified by an approved panel physician.

Signature of Employee	Date
Signature of Supervisor	Date

Valley Health Occupational Services 607 East Jubal Early Drive Winchester, VA 22601	Kevin Culbert, DO	540-536-2200
Amherst Family Practice 1867 Amherst St Winchester, VA 22601	Harry Nelson III Gustin, MD Megan Williams , DO Patricia Houser, MD William Bender, MD	540-667-8724
MedExpress Martinsburg Urgent Care Center 83 Retail Commons Parkway Martinsburg, WV 25403	Etosha Dickson, MD Kolawale Oshiyoye, MD William Dressler, MD	304-264-9730
MedExpress Martinsburg, WV Urgent Care Center 1355 Edwin Miller Blvd. Suite A Martinsburg, WV 25404	Ambroz Allessandro , MD Etosha Dickson, MD John Giangola, MD Kathryn Reihard, MD Mikela Swenson, MD Reed Erickson, MD	304-263-6753

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WINCHESTER, CITY OF
WORKERS COMPENSATION PANEL OF PHYSICIAN

MedExpress Urgent Care Winchester 207 Gateway Drive Winchester, VA 22603	Ralph Rickel, MD	540-535-1029
Medics USA - Winchester 290 Front Royal Pike Winchester, VA 22602	Khodaidad Basharmal, MD	540-662-5300
Mountain View Family Medicine 33674 Old Valley Pike Strasburg, VA 22657	Thomas Edward Holthus, DO	540-465-3751
Valley Health Occupational Services 97 Administrative Drive Martinsburg, WV 25404	Kirsten Zeiss, MD Nandita Subedi, MD	304-350-3200
Valley Health Urgent Care 607 East Jubal Early Drive Winchester, VA 22601	Kirsten Zeiss, MD Mark R Jones, MD	540-536-2232
Valley Health Urgent Care &Occupational Health Warrenton 120 N Commerce Ave Front Royal, VA 22630	Laura Lawson, DO	540-635-0700
Winchester Urgent Care 2505 Valley Avenue Winchester, VA 22601	Harjit Bagri, MD	540-665-0084

WINCHESTER, CITY OF
WORKERS COMPENSATION PANEL OF PHYSICIAN

Specialist Panel

* This panel is to only be used after the employee was referred to a specialist by a general practitioner above.

Hands

Bone & Joint Specialists of Winchester 190 Campus Blvd #310 Winchester, VA 22601	Martin Baechler, MD	540-667-9252

Orthopaedic

Bone & Joint Specialists of Winchester 190 Campus Blvd #310 Winchester, VA 22601	Dwight Kemp, DO James Larson, MD Richard Patterson, MD Thomas Courtney, MD William Cooper, DO	540-667-9252
Winchester Orthopaedic Associates 128 Medical Circle Winchester, VA 22601	Abbey Gore, MD Stephen Martenson, MD Thomas Wise, MD Winston O Cameron, MD	540-667-8975

Orthopaedic Back and Spine

Winchester Orthopaedic Associates 128 Medical Circle Winchester, VA 22601	John Zoller, III, MD	540-667-8975

EMPLOYEE INCIDENT REPORT FORM

- **All job-related injuries or illnesses – regardless of extent call 1-877-234-0898 to speak to a nurse 24/7, 365 days a year.**
- Report the accident immediately to your supervisor and a physician chosen from the PANEL OF PHYSICIANS must be used if medical treatment is needed.
- If a panel physician is unavailable at the time of an emergency, an emergency facility may treat you; however, any follow up care must be rendered by the physician chosen by you from the Panel of Physicians.
- In addition to calling the nurse hotline above, **this form must be completed by the employee and supervisor and emailed to Michael.Bozeth@winchesterva.gov within 24 hours of all incidents.**

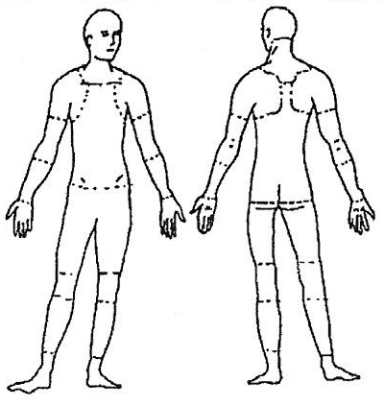
First Name:	Last Name:	Job Title:	
Date of Injury:	Hour: AM☐ PM☐	Time Left Work: AM☐ PM☐	Employee Number:
Department Name:	Name of Supervisor:	Date Reported to Supervisor:	
Exact Location of Accident:		Name of Witness:	

Describe Accident (What was injured worker doing; what objects, machines or materials were involved):

Regular Days Off:	Working Shift AM PM to AM PM

What part of your workday? ☐Entering or leaving work ☐Doing normal work activities

☐During meal period ☐During break ☐Working overtime ☐Other_____



Please circle part(s) of body affected

BODY PART INJURED

☐HEAD ☐FACE ☐EYE
☐NECK ☐BACK ☐CHEST
☐ARM ☐HAND ☐FINGER
☐LEG ☐KNEE ☐ANKLE
☐FOOT ☐TOE
☐OTHER _____

NATURE OF INJURY

☐ABRASION ☐LACERATION ☐PUNCTURE
☐BRUISE ☐FRACTURE ☐BURN
☐SPRAIN/STRAIN ☐FOREIGN BODY ☐POISON
☐COLD INJURY ☐HEAT NJURY ☐DEMATITIS
☐LOSS OF CONCIOUSNESS ☐OCCUPATIONAL ILLNESS

☐RESPIRATORY ☐OTHER_____

Employee Signature: _____ Date: _____

SUPERVISOR'S INVESTIGATION OF INCIDENT

Result of Incident:

☐ FIRST AID CASE ONLY ☐ HOSPITALIZED ☐ TIME LOSS
☐ REQUIRED DOCTOR'S CARE ☐ RECORD ONLY ☐ DEATH

Did you personally view the incident site? ☐ Yes ☐ No	Employee Category ☐ Part Time ☐ Full Time ☑ Temporary
Names of witnesses (if any):	
Written witness statements/photographs/maps / drawings attached?	
What personal protective equipment was being used (if any)?	
Description continued on attached sheets: ☐	

UNSAFE ACTS

- ☐ OPERATING WITHOUT AUTHORITY
- ☐ FAILURE TO WARN OTHERS
- ☐ OPERATING OR WORKING AT UNSAFE SPEED
- ☐ MAKING SAFETY DEVICES INOPERATIVE
- ☐ FAILURE TO SECURE OBJECTS
- ☐ USING UNSAFE EQUIPMENT OR EQUIPMENT UNSAFELY
- ☐ UNSAFE LOADING, LIFTING, CARRYING
- ☐ TAKING UNSAFE POSITION OR POSTURE
- ☐ HORSEPLAY
- ☐ FAILURE TO USE PERSONAL PROTECTIVE DEVICES
- ☐ FAILURE OT OBSERVE SAFETY REGULATIONS
- ☐ LACK OF TRAINING OR KNOWLEDGE
- ☐ PREVENTABLE VEHICLE ACCIDENT
- ☐ SLIPS AND FALLS
- ☐ FAILURE TO LOCK OUT/TAG OUT
- ☐ OTHER: _____

UNSAFE CONDITIONS

- ☐ IMPROPERLY GUARDED EQUIPMENT OR MACHINE
- ☐ DEFECTIVE TOOL OR EQUIPMENT
- ☐ POOR HOUSEKEEPING
- ☐ IMPROPER LIGHTING
- ☐ IMPROPER VENTILATION (DUST, FUMES, ETC.)
- ☐ UNSAFE DESIGN OR CONSTRUCTION
- ☐ SLIPPERY OR OTHER UNSAFE SURFACE
- ☐ INADEQUATE WARNING SYSTEM
- ☐ HAZARDOUS STORAGE OR ARRANGEMENT
- ☐ HAZARDOUS DRESS OR APPAREL
- ☐ HAZARDOUS WORK PROCEDURE
- ☐ HAZARDOUES WEATHER OR ENVIRONMENT
- ☐ CONTACT WITH POISONOUS PLANTS, INSECTS, TOXIC CHEMICALS, SKIN IRRITANTS, BITES, ECT.
- ☐ OTHER: _____

Why did the unsafe conditions exist?
Why did the unsafe acts occur?
Is there is a shortcut (such as "the job can be done more quickly" or "the product is less likely to be damaged" that may have encouraged the unsafe conditions or acts? ☐ Yes ☐ No
If yes, describe:
Were the unsafe acts or conditions reported prior to the incident? ☐ Yes ☐ No
Have there been similar incidents or near misses prior to this one? ☐ Yes ☐ No

What changes do you suggest to prevent this incident from happening again?

☐ Stop this activity ☐ Guard the hazard ☐ Train the employee(s) ☐ Train the supervisor(s)
☐ Redesign task steps ☐ Redesign work station ☐ Write a new policy/rule ☐ Enforce existing policy
☐ Routinely inspect for the hazard ☐ Personal Protective Equipment ☐ Other: _____

What should be (or has been) done to carry out the suggestion(s) checked above?

Please see reverse side for additional information

IF WARRENTED, WHAT PRACTICAL CORRECTIVE ACTION WILL BE TAKEN BY SUPERVISION TO PREVENT RECURRENCE?

Note: The wording "be more careful" is unacceptable, as it does not present a viable solution. If the cause is properly identified, there should be several solutions.

_____

_____

_____

SUPERVISOR'S SIGNATURE _____ DATE _____

MANAGEMENT REVIEW SIGNATURE _____ DATE _____

DEPARTMENT HEAD'S SIGNATURE _____ DATE _____

Please see reverse side for additional information